Medical Encounter Form

Name: _____

REASON FOR MEDICAL VISIT (list any medical concerns, issues or persistent problems, including symptoms and the onset of symptoms.) _____

*List current medications on back.

_____
Signature of staff person/date

_____
Title

REPORTS FROM THE DOCTOR (include diagnosis) _____

INSTRUCTIONS TO THE PARENT/ GUARDIAN AND PROGRAM _____

FOLLOW UP NEEDED (please include any medications, return visits). PLEASE LIST ANY REFERRALS FOR FURTHER EVALUATION TO SPECIALISTS OR HOSPITAL. _____

_____
Signature of person completing/date

_____
Title

IF THIS IS A CONTAGIOUS CONDITION, PLEASE NOTE ANY PRECAUTIONS TO PARENT/ GUARDIAN AND STAFF TO REDUCE OR PREVENT THE SPREADING OF THE ILLNESS.